New Hamshire Bureau of Developmental Services

HEALTH CARE PRACTITIONER (HCP) VISIT FORM

To be completed by individual's provider

Name:	**Date And Time Of Appointment:** **Name of Health Care Practitioner:**
Allergies:	
Reason for Visit/Symptoms:	

The following section to be completed by the health care practitioner

Results/Diagnosis:

Test/Treatment Ordered:

New Medications Ordered/Medication Order Change*:

Name	Dose	Frequency	Route	Reason Prescribed	Special Instructions

Follow-up for this problem: **Date/Time:**

Follow-up for other problem(s) identified at this visit: **Date/Time:**
Explain:

If vital signs are indicated, please give parameters and when to call the health care practitioner.

Health Care Practitioner signature:_____Print name:_____

To be completed by the individual's provider

Staff Follow-up:

☐ **Yes** ☐ **No** ☐ **N/A Transcribed orders to med log**
☐ **Yes** ☐ **No** ☐ **N/A Communicated results of visit to co-workers/supervisor**
☐ **Yes** ☐ **No** ☐ **N/A Picked-up pharmacy/medication/treatment forms**
☐ **Yes** ☐ **No** ☐ **N/A Notified Day Program of any medication changes**
☐ **Yes** ☐ **No** ☐ **N/A Guardian/health care agent/family notified**
☐ **Yes** ☐ **No** ☐ **N/A Consultation arranged**
☐ **Yes** ☐ **No** ☐ **N/A Completed lab/X-ray** **Date_____**
☐ **Yes** ☐ **No** ☐ **N/A Scheduled lab/X-ray** **Date_____**

Staff Signature (Person accompanying patient): _____